

# SOUTHWEST FAMILY PHYSICIANS PATIENT REGISTRATION

Please answer all questions

## PATIENT INFORMATION

Date \_\_\_\_\_ Account# \_\_\_\_\_

Name \_\_\_\_\_

Address: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ S.S. # \_\_\_\_\_ DL # \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Referred by: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone # ( ) \_\_\_\_\_

If patient has ever been known under another name, list \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Please give full name of person to contact in case of emergency, preferably the name of a person who does not live with you.

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

## IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE THE FOLLOWING

Name \_\_\_\_\_

Address: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ S.S. # \_\_\_\_\_ DL # \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone # ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Birthdate \_\_\_\_\_

## INSURANCE INFORMATION

INFORMATION MUST BE COMPLETED FOR INSURANCE COMPANY TO BE BILLED

### **PRIMARY INSURANCE INFORMATION**

Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Claim Address \_\_\_\_\_

Policy Holder \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Effective Date \_\_\_\_\_

ID # \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Group # \_\_\_\_\_ CoPay \_\_\_\_\_

## FAMILY MEMBERS

	<u>Birthdate</u>	<u>HOME #</u>	<u>WORK #</u>
1. Self	_____	_____	_____
2. Spouse	_____	_____	_____
		<u>SCHOOL NAME</u>	<u>SCHOOL #</u>
3. Child	_____	_____	_____
4. Child	_____	_____	_____
5. Child	_____	_____	_____

I give permission to leave a message at (circle) Home Work None

Signature \_\_\_\_\_

**THERE WILL BE A \$25 FEE FOR MISSED APPOINTMENTS**